§§ 52.2420(c)(117) and 52.2424 and the amendment to the table in § 81.347 are withdrawn.

[FR Doc. 97–11123 Filed 4–25–97; 11:54 pm]

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 433

[MB–112–F]

Medicaid Program; Third Party Liability (TPL) Cost-Effectiveness Waivers

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Correcting amendment.

SUMMARY: This document makes technical corrections to final regulations published on July 10, 1995, at 60 FR 35498, concerning Medicaid agencies' actions where third party liability (TPL) may exist for expenditures for medical assistance covered under the State plan.

EFFECTIVE DATE: These amendments are effective as of September 8, 1995, the effective date of the final rule that contained the errors.

FOR FURTHER INFORMATION CONTACT: Deborah Helms, (410) 786–7132.

SUPPLEMENTARY INFORMATION: Final regulations published on July 10, 1995, at 60 FR 35498 amended 42 CFR part 433 to revise Medicaid regulations concerning Medicaid agencies' actions where third party liability (TPL) may exist for expenditures for medical assistance covered under the State plan. The regulations allow Medicaid agencies to request waivers from certain procedures in regulations that are not expressly required by the Social Security Act. In the regulations, we unintentionally deleted the entire text of § 433.139(b)(3) through an error in our amendatory language and presentation of the CFR text. Consequently, we need to restore the deleted text in § 433.139(b)(3). This document corrects the error by amending § 433.139, to reinstate the deleted language.

List of Subjects in 42 CFR Part 433

Administrative practice and procedure, Claims, Grant programs—health, Medicaid, Reporting and recordkeeping requirements.

42 CFR Part 433 is corrected by making the following correcting amendments:

PART 433—STATE FISCAL ADMINISTRATION

1. The authority citation for Part 433 continues to read as follows:

Authority: Secs. 1102, 1137, 1902(a)(4), 1902(a)(18), 1902(a)(25), 1902(a)(45), 1902(t), 1903(a)(3), 1903(d)(2), 1903(d)(5), 1903(o), 1903(p), 1903(r), 1903(w), 1912, and 1919(e) of the Social Security Act (42 U.S.C. 1302, 1320b–7, 1396a(a)(4), 1396a(a)(18), 1396a(a)(25), 1396a(a)(45), 1396a(t), 1396b(a)(3), 1396b(d)(2), 1396a(d)(5), 1396b(i), 1396b(o), 1396b(p), 1396b(r), 1396b(w), and 1396k.

2. Section 433.139 is amended by adding paragraph (b)(3) to read as follows:

§ 433.139 Payment of claims.

* * * * *

(b) *Probable liability is established at the time claim is filed.* * * *

(3) The agency must pay the full amount allowed under the agency's payment schedule for the claim and seek reimbursement from any liable third party to the limit of legal liability (and for purposes of paragraph (b)(3)(ii) of this section, from a third party, if the third party liability is derived from an absent parent whose obligation to pay support is being enforced by the State title IV–D agency), consistent with paragraph (f) of this section if—

(i) The claim is prenatal care for pregnant women, or preventive pediatric services (including early and periodic screening, diagnosis and treatment services provided for under part 441, subpart B of this chapter), that is covered under the State plan; or

(ii) The claim is for a service covered under the State plan that is provided to an individual on whose behalf child support enforcement is being carried out by the State title IV–D agency. The agency prior to making any payment under this section must assure that the following requirements are met:

(A) The State plan specifies whether or not providers are required to bill the third party.

(B) The provider certifies that before billing Medicaid, if the provider has billed a third party, the provider has waited 30 days from the date of the service and has not received payment from the third party.

(C) The State plan specifies the method used in determining the provider's compliance with the billing requirements.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Programs)

Dated: April 17, 1997.

Neil J. Stillman,

Deputy Assistant Secretary for Information Resources Management.

[FR Doc. 97–11023 Filed 4–28–97; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

42 CFR Part 1004

RIN 0991–AA86

Health Care Programs: Fraud and Abuse; Revised PRO Sanctions for Failing To Meet Statutory Obligations

AGENCY: Office of Inspector General (OIG), HHS.

ACTION: Final rule.

SUMMARY: This final rule addresses revised procedures governing the imposition and adjudication of program sanctions, based on recommendations from State utilization and quality control peer review organizations (PROs), resulting from enactment of sections 214 and 231(f) of the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

EFFECTIVE DATE: These regulations are effective on April 29, 1997.

FOR FURTHER INFORMATION CONTACT: Joel J. Schaer, Office of Counsel to the Inspector General, (202) 619–0089.

SUPPLEMENTARY INFORMATION:

I. Background

The PRO Sanctions Process

Section 1156 of the Social Security Act imposes specific statutory obligations on health care practitioners and other persons to furnish medically necessary services to Medicare and State health care program beneficiaries that meet professionally recognized standards of health care. The statute authorizes the Secretary—based on a PRO's recommendation—to impose sanctions on those who fail to comply with these statutory obligations.

Under the PRO sanctions process as originally established, no practitioner or other person was subject to a program exclusion or a momentary penalty until the practitioner or other person had received notice of the proposed sanction and had an opportunity to respond, including a discussion with the PRO. After the receipt of a recommendation from a PRO, the OIG, delegated the Secretary's authority, was authorized to impose an exclusion or a monetary penalty after a careful review of all